Creating dialogue on culture and bias in the learner-teacher relationship

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Dialogue between clinical teachers and learners about bias encountered by certain populations in health care can be difficult. As physicians, in addition to having individual identities and different backgrounds and lived experiences, we belong to our own professional subculture, and reflecting on our privilege can be uncomfortable. We all hold implicit biases that might affect not only our ability to learn openly about and from others but also our ability to provide equitable care.[1,2] It is only by first critically reflecting on our own biases and the power differentials that exist within the patient-physician relationship that we can move toward providing care less affected by implicit bias.

Current events have moved concepts of race and racism into increased prominence. While we acknowledge the complexity and importance of these issues, this article is not designed to address these concepts. Our purpose is to provide a starting point for family physician teachers to consider culture and bias using their own practice in discussion with learners.

Honouring the origin of cultural safety

The concept of cultural safety originated in New Zealand to address service delivery to the indigenous Māori peoples.[1] It has been widely adopted internationally as a framework to address the power differentials that patients of diverse groups experience. The concept acknowledges that both patients and physicians bring beliefs, values, and perspectives to the encounter and that each can be safe in retaining this identity.

Cultural safety and the patient-centred clinical method

Cultural safety is a familiar concept to family physicians knowledgeable in the patient-centred clinical method. The patient-centred clinical method grounds every patient interaction with a shared decision-making process that is integrated with an understanding of the patient's lived experience, values, beliefs, and context.[2] The patient-centred clinical method is focused on ensuring that every patient experiences culturally safer care. The term *equity-oriented health care* encompasses further elements that can affect the equitable delivery of health care, incorporating the tenets of trauma and violence-informed care, culturally safer care, and harm reduction. Cultural safety and equity-oriented health care are important concepts that link with both the 2019 College of Family Physicians of Canada CanMEDS–Family Medicine undergraduate competencies (eg, communicator, advocate, professional) and the work of the College's Indigenous Health Committee.[3,4]

This article is intended to assist teachers with initiating conversations about culturally safer care and how to provide equity-oriented health care. It can be used with diverse patient populations, as each community will differ in its definition of culture.

Steps toward culturally safer care

Several terms are used to describe human beings' complex relationships with cultures, both those we identify with individually and those of others. A stepwise approach can assist teachers (**Figure 1**).[5-9] Teachers must first be grounded in *cultural humility,* an approach of self-reflection and openness to understanding biases and learning about others.[5] *Cultural awareness* is the recognition that differences and similarities exist between cultures; *cultural sensitivity* identifies that a respect of these differences between people is important; and finally, *cultural competence* is the development of knowledge, skills, and attitudes to work with diverse groups of people.[6,7] Cultural awareness, sensitivity, and competence place the focus on learning about the patient but do not address the power differentials between health care providers and patients.[8,9] To move toward culturally safer care, family medicine teachers must self-reflect, examining those power differentials with the objective of providing equity-oriented health care.

The ideas provided in this article represent a starting point only and are not intended to be prescriptive; teachers can use them in a way that reflects their practice and their community and the readiness of both learners and teachers to begin the conversation. The creation of a safe, nonthreatening learning environment is critical in approaching these questions.

Considering culture and addressing bias

To begin to understand the cultures of others, we must first reflect on our own.[10,11] Culture represents more than our ancestry; it reflects the identity of a group or groups to which we identify or feel a sense of belonging (eg, ethnicity, work, religion, ability, language, politics, gender, orientation, etc). We encourage teachers to consider these questions themselves (**Box 1**)[10-12] before engaging in conversation with learners. The role of the preceptor is to encourage self-reflection; however, learners might not want to openly disclose their responses.

Putting reflection into action

Defining and overcoming biases involve both learners and teachers in internal reflection. Subsequently, in day-to-day clinical encounters with patients, a teacher might choose to use further questions (**Box 1**)[10-12] to guide the student into a deeper self-reflection as well as into action to create culturally safer care.[10]

Teachers should consider asking learners to think of a specific encounter with a patient. The encounter need not have been a problematic one, as teachers should encourage learners to become familiar with their implicit biases in every encounter. Some or all of the questions listed in **Box 1** can be used to guide the conversation as both teachers and learners engage in self-reflection.[10-12] Learners should be encouraged to link their reflections to the stepwise approach to culturally safer care (**Figure 1**).[5-9] Remember to create a safe learning space.

Conclusion

As we create culturally safer practices, our learners will push us as teachers further to address issues of bias, inclusion, and exclusion at a systemic level. The goal of these guiding questions is to help learners feel comfortable within their own culture as it might express itself in the clinical encounter, while also ensuring that patients feel the same safety.

Box 1. Questions for self-reflection

What is culture?[10,11]

- Which culture or cultures do I belong to? How do I know?
- What advantages does identifying with this culture afford me? Can I think of an example of this advantage from today or this week?

Overcoming bias[12]

- Who are the people in my community who might be subject to bias?
- What stereotypes and implicit associations do I have of those groups?
- Where did I get this information?

Putting reflection into action[10]

- Was I cognizant of my biases?
- Why did I see the situation in a particular way?
- Why did I respond the way I did?
- What did I focus on or overlook?
- How did my beliefs influence this interaction? Is this bias affecting my ability to care for this patient?
- What do I need to learn more about? Where can I seek this information?
- Did I enter into a true partnership? (This might be appropriate for a higher-level learner)

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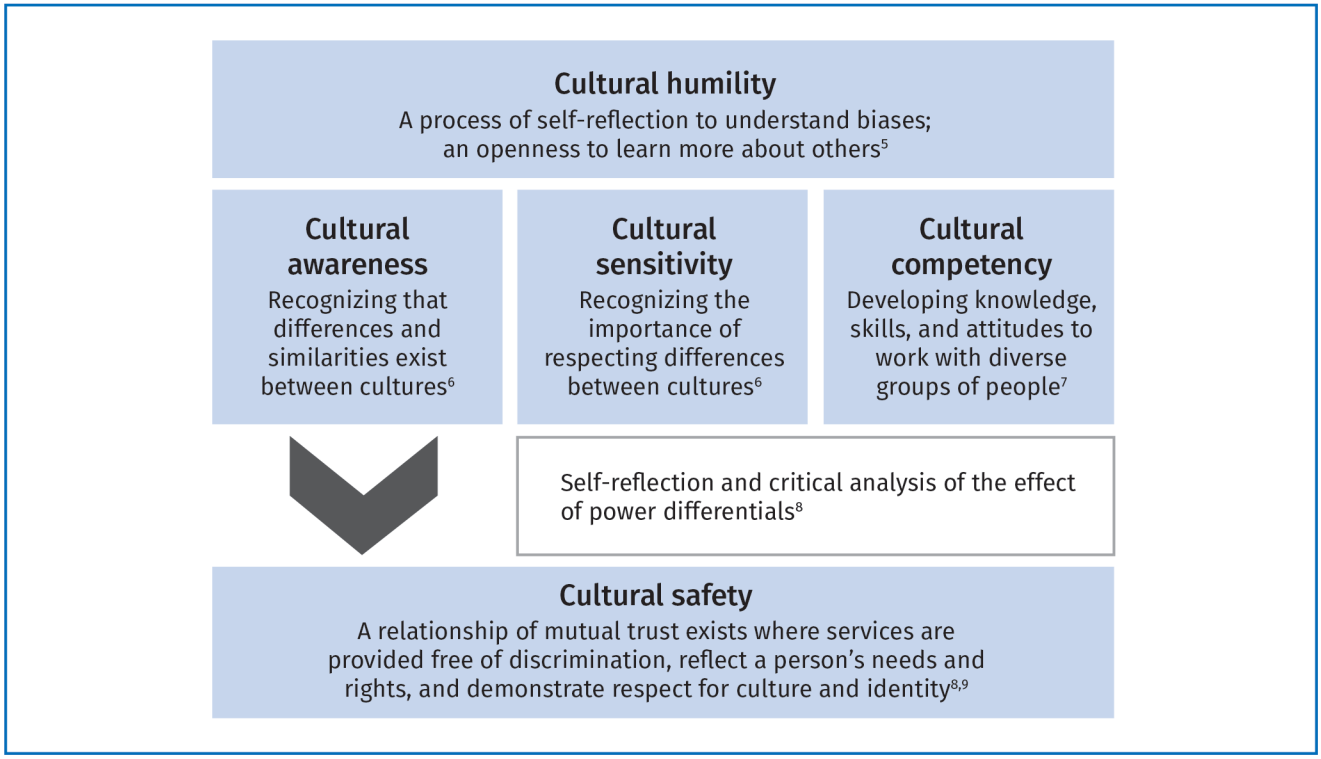
Figure 1. A stepwise approach to culturally safer care



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Teaching tips

- Before engaging with learners, reflect on your own personal beliefs, values, and perspectives. Create a safe learning space before initiating conversation.
- Use questions to guide learners into deeper self-reflection about their own culture and how their implicit biases might be expressed in the clinical encounter. Recognize that learners might not wish to disclose their responses.
- Ask the learner to consider a specific encounter with a patient. Encourage learners to become familiar with their implicit biases in every encounter, not just problematic ones.
- Encourage learners to link their reflections to the stepwise approach to culturally safer care.

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